Trauma Focus Group Therapy for Combat-Related PTSD

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Although individual therapy involving imaginal experiencing of the traumatic event has been found to be effective in treating PTSD, there is evidence that few trauma therapists actually use the technique. Moreover, symptom improvement has been found to favor intrusive symptoms, whereas avoidance and hyperarousal have been less affected. Additionally, there are several published reports documenting difficulties in implementing the treatment, ranging from client refusal, adverse reactions, and therapist inexperience. In this article we outline an alternative group form of exposure therapy, manualized trauma focus group therapy (TFGT), designed to overcome some of these implementation obstacles and to enhance the effects of imaginal exposure to include those chronic PTSD symptoms of avoidance and social isolation. We describe the cognitive behavioral and developmental models from which the approach was derived, present clinical guidelines and an illustrative session, discuss complications we have encountered in TFGT pilot studies, and offer suggestions for improving future implementation.

• combat-related PTSD • exposure therapy • manualized treatment • group therapy • relapse prevention • cognitive restructuring • coping skills

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Posttraumatic stress disorder (PTSD) was formally introduced into the diagnostic system with the third edition of the American Psychiatric Association's *Diagnostic and statistical manual of mental disorders (DSM–III)* in 1980. However, specific psychiatric syndromes had been described much earlier in association with the combat-related problems found among veterans of the two world wars. In contrast to the more narrowly defined concept of "shell shock" generated during World War I, detailed case histories of many World War II veterans described a wide variety of psychological problems following combat. The symptom picture that was presented included classic PTSD features, such as anxiety attacks, depression, suicidal and homicidal ideation, sleep difficulties, and combat-related nightmares. Research findings and clinical experience since 1980 have expanded the range of traumagenic experiences known to cause the reexperiencing, avoidance, and hyperarousal symptom patterns characteristic of the disorder. Even so, combat veterans remain one of the largest populations of clinical concern, both in this country and internationally.

TRAUMA FOCUS GROUP THERAPY

The primary objective of trauma focus group therapy (TFGT) for combat-related PTSD is to enhance members' control of chronic symptoms of PTSD. Improving self-control and quality of life in those whose lives have been controlled by their symptoms is seen as taking precedent over immediate symptom reduction as the longer term outcome to be sought. Emphasizing this objective takes into account the intractable nature of chronic PTSD insofar as life-long risk for symptom exacerbation is concerned. However, the approach challenges members to adopt realistic goals of living fuller lives while managing risks of periodic symptom exacerbation.

TFGT emphasizes systematic prolonged exposure and cognitive restructuring applied to each individual's selected combat-related traumatic experience, and relapse prevention training to enhance members' coping skills and resources for maintaining control over specific PTSD and related symptoms. Our cognitive–behavioral model of TFGT is set in a developmental perspective, taking into account important relationships and experiences occurring across the entire life span (over premilitary, war zone, and postmilitary time frames) for group members who are now in middle adulthood (Gusman et al., 1996). Thus, our model features an autobiographical emphasis that combines both individual narrative construction and the group concept of having others bear witness by listening to members' public recounting of their significant life experiences. In addition, the model incorporates combat-trauma processing by encouraging group members to experience repeatedly their personal tragic events, as well as to be vicariously exposed to the experiences of other group members. Relapse prevention planning is a final core component of TFGT. Emphasis on mobilizing coping resources to be used in predictable high-risk situations is intended to help maintain treatment gains between sessions and after TFGT is completed.

From a cognitive–behavioral perspective, prolonged, repeated exposure to significant elements within traumatic memories is necessary to reduce trauma-related fears and to accomplish desensitization to related cues (reminders of the trauma). Imaginal exposure is a format used, as it is often impractical or impossible to recreate the actual original traumatic situation(s). Accordingly, treatment of victims

whose traumatic experiences are remote, through time or distance factors, such as adult incest and combat-related PTSD, is often accomplished through imaginal presentation of the feared memories in which members retell their own most personal fear-related situations. Prolonged exposure is also useful in correcting faulty perceptions of danger that may develop, by spreading to similar situations, the fears derived from traumatic experiences. In our TFGT procedures we address the need for repeated exposures to combat-related traumatic memories by devoting one third of all sessions to individualized focus work on war zone combat experiences. This extensive exposure element, along with guided rethinking about the cause and meaning of the trauma, is the core TFGT treatment component. Thus, it necessarily occupies the largest percentage of the total group treatment time.

Mowrer's (1960) two-factor theory is often used to explain the origin and persistence of PTSD symptoms, such that the initial trauma reaction becomes a conditioned emotional response, and subsequent avoidance responses are motivated by fear and reinforced by fear reduction. Other learning principles postulated as factors in the maintenance of anxiety and distress include the process whereby new cues that are similar to the conditioned cues can also come to elicit anxiety (stimulus generalization). A primary clinical implication of a two-factor formulation is that trauma severity accounts for the development of PTSD symptoms. A second implication is that coping by avoidance of distress-producing reminders must be overcome if symptoms are to be reduced. This basic learning model is limited, however, in that it cannot account for positive cases of PTSD following low exposure, nor does it account for noncases among those individuals who are highly exposed. In actuality, many trauma survivors are encountered who represent these exceptions.

Our cognitive–behavioral conceptualization of PTSD (see Foy, 1992) is an interactional model that is used to account for the interplay of trauma characteristics (agent), personal factors (host), and other factors (environment) in the development of acute or chronic PTSD. Such a model allows for individual differences on other important factors, such as social support or cognitive attributions about the cause and meaning of the trauma (Foa & Meadows, 1997) to be incorporated in case conceptualization.

Many individuals suffering from chronic PTSD have come to rely heavily on avoidance of traumatic reminders as a primary form of coping with their PTSD. Returning to such a strategy following exposure-based treatment, however, constitutes relapse in our conceptualization of the disorder. Current cognitive–behavioral relapse prevention formulations emphasize developing active coping skills to deal with clients' personal high-risk situations. The pioneering work of Marlatt and Gordon (1985) produced the prototypic methods, now in wide use throughout the field, used to identify tempting situations (people, places, activities, and strong emotions) associated with the problem behavior in the past. Other important contributions from this perspective on relapse prevention include the widely observed cognitive reaction of thinking that "all is lost" if a slip (lapse) occurs. This overreaction then increases risk for a return to the old pattern of out-of-control behavior (relapse) by disallowing the use of other positive methods to contain the lapse. Also important in relapse prevention is the individuals' appraisal of their abilities to identify accurately high-risk situations and use appropriate coping skills, as well as the belief that their response can make a difference in outcome (self-efficacy). Outcome expectancies are the perceived consequences of resuming the problem behavior, and an important element in the therapeutic use of expectancy is to ensure that longer

term consequences are given appropriate consideration before a decision is made about the temptation. For example, many chronic PTSD clients have a habit of isolating from others who might otherwise help when they are stressed. In the short term, isolating has the desired effect of not subjecting clients to disclosure of their difficulties and the possibility of nonsupport. In the longer term, however, failing to call on significant others in time of need is likely to make PTSD symptoms worse.

Session Design and Clinical Sequence

There are six group members and two group facilitators in each war trauma focus group. Each session is organized to include five core elements: check-in, review of homework, specific topics, assignment of homework, and check-out.

There is one group meeting each week. War zone focus sessions last 120 min; other meetings last 90 min. As outlined here, the group meets weekly for 30 sessions, or about 7 months, then monthly for another 5 months. Sessions take place according to the topics listed in Table 1.

As shown in Table 1, there are three general types of sessions. Introductory sessions have several goals. They are intended to provide education about PTSD and the treatment process, teach and reinforce basic coping skills, prepare members for their upcoming task of reexperiencing their traumatic memories, and provide group facilitators and other members with additional background information about each participant. Preparation for therapeutic exposure is accomplished by setting clear group rules and structure, building member cohesion, discussing realistic expectations for outcome, presenting a clear rationale for exposure treatment, and teaching and supporting coping skills to be consciously employed during the war zone focus section of treatment.

War zone focus sessions begin with trauma scene identification and proceed to systematic exposure to key aspects of trauma memories. They are intended to reduce fears of memories of traumatic experiences, improve perceived self-control of memories and accompanying negative emotions, and strengthen adaptive coping responses under conditions of distress.

Finally, relapse prevention and termination sessions focus on planning for anticipated difficulties in postdischarge living, identifying individual risk scenarios and positive responses, continued practicing of coping skills, providing a period for consolidation of experiences during exposure, and preparing members for group termination. Specific content for each session mirrors these goals.

Introductions, structure, and group rules. Session 1 allows introductions of members, orients members to various facets of group membership, and, generally facilitates development of an emotionally safe treatment environment.

PTSD education. Session 2 provides members with a chance to describe their own trauma symptoms and the personal impact of those symptoms. Group facilitators have the opportunity to provide didactic education and clarify misperceptions about PTSD.

Coping resources. Session 3 introduces the concept of coping by encouraging members to conduct a personal inventory of current coping resources, identifying personal strengths, and noting areas in need of development.

Negative and positive coping. Session 4 continues this theme by facilitating examination of negative coping behaviors used in the past by group members (e.g., alcohol consumption, social isolation, anger, and violence) and their consequences, and positive alternatives (e.g., finding support from significant others, practicing relaxation).

TABLE 1. *Schedule and session topics for war trauma focus group*

Session no.	*Session topics*
Introductory sessions	
1	Introductions, structure, and group rules
2	PTSD education
3	Coping resources
4	Negative and positive coping
5	PTSD symptoms and self-control
6–7	Premilitary autobiographies
8	Pre-War zone military autobiographies
War zone focus sessions	
9–10	War zone trauma scene—Identification/coping review
11–22	War zone trauma exposure and cognitive restructuring
Relapse prevention and termination	
23	Integrating trauma: The three-way mirror
24	Improving social support
25–26	Anger management
27–28	Risk situations and coping strategies
29	Behavioral contracting
30	Transitioning to monthly sessions
Booster (5 sessions)	Integration of traumatic experience and relapse prevention

PTSD symptoms and self-control. Session 5 emphasizes the importance of responding positively to symptoms, for example, taking action to manage arousal, control attention, and enlisting social support. It also helps members recognize that treatment will not eliminate all PTSD symptoms and that coping will mean acting to reduce their intensity and duration and minimize their negative consequences.

Premilitary autobiographies. Sessions 6–7 provide members with a chance to explore briefly, in a structured way, their childhood and adolescence to help establish their identities before experiencing combat trauma. Key developmental themes are reviewed that are related to early life coping and response to trauma, including relationships with family members and peers, religious and cultural background, and pre-war traumatic experiences.

Pre-War zone military autobiographies. Session 8 presents members with a similar opportunity to examine early attitudes toward military life and war, as well as ways in which basic military training affected their responses to war traumas.

War zone trauma scene—Identification/coping review. Sessions 9–10 are designed to help each member select the trauma scene that he will review during his personal trauma focus work. Members are encouraged to select scenes that are especially distressing, associated with current symptomatology or vivid imagery, associated with fear as the predominant affect, and/or connected with guilt and shame or other troubling cognitions. Each member gives a very brief description of his traumatic combat experience, and those who need help in identifying their events are coached to specify a scene. They are given a brief "walk-through" of their war zone experience and prompted to focus on likely traumagenic episodes: moment of greatest perceived life threat, memories of being wounded or killing the enemy, and so on. If the member has several possible scenes, he is asked to rank-order them by

subjective distress to help with selection. Positive coping tools discussed in previous sessions are reviewed to prompt a coping "set" close in time to trauma-focused discussions.

War zone trauma exposure and cognitive restructuring. Sessions 11–22 are conducted by focusing upon one member at a time to ensure a minimum of 30 min of exposure to his important trauma-related reminders, and to prevent cognitive avoidance. In their narratives of their trauma scenes, members are instructed to emphasize their sensory perceptions, thoughts, and emotional reactions that occurred during the incident. During recounting of the traumatic experience, minimal prompts are given by the facilitators, as the therapeutic objective is to encourage the member to assume responsibility for "self-exposure." Overall, the task might best be conceptualized as "supported remembering."

After the member describes his traumatic experience, negative thoughts are identified and challenged. In turn, each member is allocated one session for this work; after each has had a turn, the process is repeated so members can be exposed to the material a second time in group. It is important to note that, following the initial in-session exposure, the member is asked to begin an extragroup self-exposure process as homework. The purpose of the exposure homework is to increase the number of times trauma scenes are reexperienced (exposure dose) to ensure that fears are effectively reduced. He is given a cassette recording of his trauma narrative and the related cognitive restructuring, asked to listen to the recording at least once during the next week, note distress levels, and report on coping skills used to manage resultant distress.

Originally, traumatic events may have been so intense that they overwhelmed the member's capacity to comprehend them accurately (Foa & Meadows, 1997). Often, the simple sequence of events in the scene is unclear to the survivor. Thus, many survivors draw inaccurate inferences from the events, which involve misperceptions about culpability for the tragic outcome. Accordingly, the goal of the self-exposure process is to access painful memories but to prevent overwhelming negative emotion. Facilitators focus attention on key trauma reminders, help prevent avoidance, and assist with management of distress as necessary. In the cognitive restructuring phase following the member's narrative account of his scene, facilitators and other group members assist the member by carefully and systematically evaluating the "data" supporting the inferences and beliefs the member holds about his scene.

As detailed by Carroll and Foy (1992), this evaluation includes four phases:

1. Identifying the key points or critical junctures in which actions taken (or not taken) are seen as contributing to the tragic outcome.
2. Determining whether the events occurring after these key points that led to the tragic outcome were *predictable or controllable.*
3. Revising attributions made of culpability, based on an accurate review of predictability and controllability factors.
4. Considering how ideas about culpability are related to the member's current world view (i.e., regarding core trauma themes such as safety, trust, and power/control), and how revisions in these notions about culpability may permit more flexibility in the world view.

Integrating trauma: The three-way mirror. Session 23 is designed to aid the transition of the group from trauma focus work to a current perspective in which inte-

gration of traumatic experiences and relapse prevention are emphasized. The mirror metaphor is used to represent each member's life in developmental perspective: premilitary, military, and postmilitary/current timeframes.

Improving social support. Session 24 focuses on helping veterans recognize the importance of support from significant others for relapse prevention, reviewing current key relationships, identifying problems in these relationships, and developing (and implementing as homework) action plans for improving them.

Anger management. Sessions 25–26 direct members' attention to the links between their past traumatic experiences and current anger, and the negative consequences of anger in their present lives. It also helps them to identify positive anger control strategies, generate individualized plans, and practice some of these strategies in session and as homework.

Risk situations and coping strategies. In Sessions 27–28 members complete structured exercises to identify personal high-risk situations and specify steps for constructive coping. They also prepare personalized "emergency cards," which they carry with them to prompt more effective coping in emergencies.

Behavioral contracting. Session 29 cements this process of relapse prevention planning by formalizing each member's commitment to coping in a written contract.

Transitioning to monthly sessions. In Session 30 members review lessons learned, develop implications for the future, and discuss feelings about moving from weekly to monthly meetings.

Booster Sessions. Five additional sessions are designed to continue the work of trauma integration and relapse prevention within the group while members are gradually weaned from their dependence upon the group. Trouble-shooting difficulties members encounter in keeping their rehabilitation contracts are the primary activity within these sessions. As necessary, members may be encouraged to identify and use other therapeutic supports in the community to assist them in maintaining or advancing treatment gains.

To summarize, the primary treatment principles employed in TFGT include PTSD education, prolonged exposure, cognitive restructuring, coping skills, and relapse prevention training.

CASE ILLUSTRATION

Presenting Problem/Client Description

Mark is a 48-year-old divorced, service-connected, male Vietnam veteran, referred by his VA case manager for cognitive–behavioral assessment and treatment of his chronic combat-related PTSD symptoms. His premilitary social history was unremarkable in that there was no reported abuse, no indications of severe family dysfunction, and indications of positive school adjustment through his timely completion of high school. He served in the Marines, with training as a rifleman and supply clerk. His tour of Vietnam duty included several instances in which his unit was exposed to heavy combat and suffered casualties, although Mark himself was not wounded.

After Mark's discharge from military service, he was employed as a stock clerk in a succession of entry-level jobs, several of which he eventually walked away from after disputes with supervisors. He has a history of two prior marriages, each of

which produced one child with whom he has intermittent contacts, and he is currently in a cohabitation relationship that began about 2 years ago. Mark has a history of three brief psychiatric hospitalizations, and he has had two extensive attempts at individual psychotherapy on an outpatient basis. He also has a history of previous alcohol abuse, but he has been sober for approximately 2 years and attends AA meetings on a monthly basis. Mark has been maintained on antidepressant medication from which there has been modest improvement in mood, but no change in his PTSD symptoms. At the time of his referral he had just left his job of 8 months as a warehouseman after a disagreement with his supervisor, and was reporting increased discomfort being around other people, combat-related nightmares, and unresolved strife with his cohabitating partner.

Case Formulation

Despite Mark's positive premilitary history, his postcombat adjustment has been marginal, suggesting that profound life experiences and changes in his coping capabilities occurred during his period of military service. Although his specific traumatic experiences in combat have not yet been identified, it appears that his primary PTSD features include both reexperiencing and avoidant symptoms in the form of recurring nightmares and disrupted interpersonal relationships indicative of social isolation and mistrust. In view of his history of insignificant gains following his two previous attempts at individual therapy and his specific interpersonal difficulties, TFGT was recommended to Mark as a new form of combat-related PTSD therapy that could possibly help him achieve improvements.

Course of Treatment

Over the course of 7 months Mark participated as a member of a VA-sponsored TFGT that included five other combat veterans and two professional co-facilitators. His group met weekly for 7 months and then moved to once a month for booster sessions and transitioning out of the group. For each session one of the co-facilitators made an outline of the topics to be covered on a flip chart in the group therapy room so that members could refer to the session agenda as the group sessions unfolded. Although it made him somewhat uncomfortable at first, Mark and the other members soon became accustomed to the videotaping of each session. He agreed to the taping on the condition of confidentiality and that the tapes would be used for teaching purposes and to provide feedback to the facilitators for their performances in managing each group session.

It had been many years since Mark and the other members had been assigned school homework. However, he found that doing the weekly assignments prescribed in his own member's workbook made it easier for him to prepare for, and follow along with, weekly session topics. He also noticed that the co-facilitators had a similar requirement to follow the session guides contained in their own leaders' manuals.

Mark's response to treatment thus far was positive. He attended sessions as scheduled and completed homework assignments on all except one occasion. Because he had been prone to social isolation, it was especially noteworthy that he related well to other members of the group and appeared well motivated to begin his war zone trauma work.

The 13th session was devoted to supporting Mark as he reviewed his specific combat-related trauma in detail (i.e., exposure) and then reconsidered his assump-

tions and beliefs about the event for accuracy (i.e., cognitive restructuring), utilizing feedback and observations from both other group members and the facilitators. The following excerpt occurred about 70 min into the 2-hr session, and presents the initial work on cognitive restructuring, after Mark completed his first round of exposure to the event. Prior to Mark's 45-min exposure, each member had first participated in check-in, and had handed in his homework. The cognitive restructuring began with a reminder about the process to the group.

FACILITATOR 1: I really appreciate how hard it was for you to tell us about that event, and I can see how sad and angry it makes you. Where are you on the anxiety scale [*which ranges from 0 to 10*]?

MARK: Ten.

At this point he was sweating profusely, wiping his forehead, and his legs were shaking. Thus, it was clear that Mark's physiological arousal matched his subjective assessment of very high distress. Because the goal is to keep arousal below overwhelming levels to facilitate the cognitive restructuring work, the facilitator provides a prompt for Mark to use one of his coping skills to reduce his distress.

FACILITATOR 1: It might help you get a bit calmer if you focus on your breathing. (*Pause*) I want to remind everybody about what we are going to do now that Mark has finished describing his trauma. [*While Mark was telling us about it, Sandy, the other facilitator, was listing each key point—each point in which action was or could have been taken to influence the tragic outcome in this event—on the flip chart.*] Now in the cognitive restructuring, we want to help Mark be sure that he has an accurate understanding of the events that happened, and hasn't made any erroneous assumptions about what could be controlled and who (or what) was responsible for the tragedy. We also want to be sure we discriminate between information he knew *at the time of the event* and things he has considered or figured out much later. Now Mark will need your feedback to be sure he considers each of these issues carefully and thoroughly. We will look at each one of the key points, and try to figure out how foreseeable and controllable it was that this action would lead to the tragic outcome. Everybody got that?

Let me briefly summarize the scene. You were two weeks in country—a new sergeant. You were a supply sergeant and on this day you had the assignment of cleaning up outside the perimeter of the base after the unit faced some contact. Three of you hiked a mile or so outside the base camp to do the job. Nobody expected a problem, and you were new in country, so you were following their lead. You asked once about safety because you thought you might find live ammunition, but the corporal with a special weapons certification said "It was a piece of cake" and not to worry. The corporal told you to go out about 500 yards and start to clean up. You were surprised because it seemed unusual to you and maybe dangerous, so you asked him if he was sure. He said yes, and you followed his instruction. No one else thought there was any danger, so you weren't too worried. The other guy had a box of blasting caps in the left pocket of his shirt. As the three of you were cleaning up the area, you were cleaning up some casings, you had a second thought about safety, and then you heard a "pop"—not an explosion—and you couldn't see or hear anything. You thought you had tripped a mine and were dead. And then you looked around

and saw that the other guys were badly injured and screaming. You didn't have any way to help them, so you quickly ran back to the base camp for help.

Now look at the first key point Sandy wrote up there.

FACILITATOR 2: You used the words "negligent" and "guilt." Those are two predominant thoughts and feelings you have?

MARK: Negligence . . . there are decisions that were made that could have changed the outcome, and I had a hand in them.

FACILITATOR 2: And that's where the guilt comes in.

MARK: Yeah.

FACILITATOR 2: You feel guilty you didn't question the corporal . . . didn't let him know you were uncomfortable with the mission.

MARK: Right.

JACK [GROUP MEMBER]: And you were what? Two weeks in country? And you were reluctant to question an order? I don't see why you need to beat yourself up for that.

FACILITATOR 1: I can hear you being supportive . . . but let's make sure that Mark gets a chance to air all his concerns before we give him input.

The facilitator wants to be sure that Mark has the opportunity to identify all the key points in his scene before other group members' input is taken. This allows him to do his initial processing work without having the issues complicated by others' feedback.

FACILITATOR 2: So there was also guilt because you hadn't overridden the decision and after the explosion you realized you weren't a medic or corpsman so you couldn't help the men who were hurt.

MARK: Right. I didn't even have a first aid kit.

FACILITATOR 2: And no radio?

MARK: Right.

FACILITATOR 2: And you couldn't run fast enough to get help? Did I get that piece right here on the board? Is that what you think?

MARK: Yeah . . . I couldn't do anything right. The events pointed to my own ineptitude. I felt very responsible. I was in charge, the senior person technically, even though I was new. . . .

FACILITATOR 2: Can I ask some of your peers here how the evidence fits with your feelings?

FRANK [GROUP MEMBER]: When you went and visited the wounded men in the hospital, did you feel guilty then? Did they act like you were to blame?

MARK: I always felt so bad . . . I came out scot-free and they were in bad shape.

JACK: You know, when I was in Vietnam, we always paid attention to the experienced guys, even if they were lower in rank—the guys who had two or three tours—they knew the score. If I were new in country, even if I was in charge, I would have listened to more experienced people. That's all you had. You don't want to feel like a baby. You want assurance. I wouldn't want to question experience.

FACILITATOR 2: No matter what the rank?

JACK: Right. They knew. I would never question experience.

FRANK: How could you not defer to them? How would you back it up? At least you asked the question. You did bring it up. How is that negligence? You asked the right question of the expert.

Here, pointed confrontation of Mark's assumption about his responsibility for the incident is offered by other group members. The inconsistencies in his assumption, when viewed against other common knowledge about the circumstances of war, are being made without judgment toward Mark, offering him an opportunity to consider revising his assumption.

CHRIS [GROUP MEMBER]: I don't know. It could have been a blasting cap; you said the guy's arm was blown off. Not a mine. A blasting cap.

JACK: That's what it sounds like to me. A mine would be the legs—but a blasting cap in his shirt pocket?

FACILITATOR 1: Mark, did you ever give any thought to the idea that it may have been a blasting cap and not the mine—a blasting cap would have taken off the arm.

FACILITATOR 2: And then when everybody jumped, it might have tripped the mine.

FRANK: I remember in weapons school they used to have us set the blasting caps and crimp them behind our backs because they were so sensitive. If they went off, they were so powerful you could lose a finger—but not your face, if it was behind you. They are so sensitive—sounds like an old one that someone set off by mistake.

CHRIS: And that was the "pop" you heard. Not an explosion. A pop.

JACK: That's right. Time sequence would have been instantaneous.

FACILITATOR 2: Mark, let me summarize. A group of your peers thinks a blasting cap probably caused the arm injuries, and then someone tripped the mine. Now, what about the guilt. You talked about how you could have pushed it further about safety, but that's kind of moot if the blasting cap set it off. Now, on the board—the first aid kit, the radio—how does that fit?

MARK: Well, I have to admit that I wasn't prepared. I was the senior person. I should have had all those things.

FACILITATOR 2: So, 48-year-old Mark knows he should have been prepared. How old were you then? 22?

MARK: 21.

FACILITATOR 2: So 21-year-old Mark should have had your wisdom?

FACILITATOR 1: Was it predictable?

MARK: Predictable? I can't run from the fact that I knew that there was danger there.

FACILITATOR 2: The day that you got off the plane you knew there was danger there. I mean—you had a specially trained corporal who thought it was safe; he had done it numerous times—cleaning up the perimeter was standard operating procedure at most places.

FACILITATOR 1: Did you know it was going to happen?

CHRIS: They were all short. When I served, one of the responsibilities of the corporal and sergeants was to break in the new guys. If it had gone up for a disciplinary action, it may have been him who got the Article 15. Not you. He's the one who should have known. He's the one with the time. He gave you bum information the first few weeks—wrong information. No radio?

FRANK: I keep thinking, with the extent of the injuries, I am not sure a radio or first aid kit would have helped. You can bleed to death in one minute from a major artery. He lost his shoulder and arm. Even if you called for a dust-off, [helicopter evacuation] I don't think that they could have gotten there in time.

MARK: I guess I just do—I keep repeating—you didn't keep the guys safe, you didn't have a radio, you didn't have a first aid kit, you weren't ready. . . .

FACILITATOR 2: But you have a medic here telling you it wouldn't have made any difference if you had had that stuff.

CHRIS: Eyewash. Now how would that have helped? A first aid kit? You would have wasted valuable time. As it was, you got out of there and ran for help. You didn't delay.

FACILITATOR 1: Chris brings up a good point. And as I asked before, did anyone notice anything that made this predictable? That Mark would have known it was doing to happen? (Silence) That he could have controlled it?

JACK: I keep thinking he did the right thing. He pulled a guy from danger and got help as quick as he could under tremendous strain.

FRANK: If you were in an explosion that killed someone, it is amazing to me that you had the presence of mind to get help. A lot of guys are just shocked or run the wrong way—into the woods.

FACILITATOR 2: What about the most important point on the board—you lived and they died. As the group has said, the event was not predictable or controllable—and maybe you have come to believe that. So are you responsible? You are two weeks in country, it doesn't feel right to you, you try to tell them, we have two other members here who say that the first thing you learn is to trust and listen to the more experienced people.

MARK: What they told us over and over on arrival in country if you want to stay alive, you listen to the experienced guys.

FACILITATOR 2: And you did exactly what you were told. And in spite of that, they died. And if they had lived, and you had died, would you condemn them to be tormented like you have been? Would you have wanted them to suffer the way you have over the last twenty-five years?

MARK: No. It's a price which you pay, and you pay and pay and pay, it's too harsh of a sentence—a life sentence.

FACILITATOR 1: What did you learn today?

MARK: That there are many ways of looking at what happened. That maybe I am not responsible. That I too am human.

FACILITATOR 1: How are you feeling now?

MARK: I was afraid of judgment. That my peers would judge me. But I didn't hear that. And it was gratifying.

FACILITATOR 2: In fact, you heard experienced people supporting you and offering other plausible explanations for the events that had nothing to do with Mark. It was an accident. Where are you on that 0–10 anxiety scale?

MARK: About a 7 or so, down a little.

As can be seen, there were two key aspects of the cognitive restructuring in the session: (a) clarifying the exact sequence of events during the trauma, and (b) ascertaining whether the events were predictable or controllable. Although Mark clearly believed himself culpable for the injuries of his companions, the evidence does not necessarily support his assumption of guilt, according to other experienced members' observations. Thus, tension between his evaluations and those of respected others prompted him to begin reconsidering his self-appraisal of responsibility. This cognitive shift was accompanied by a drop in his rated anxiety level. This therapeutic work continued in Mark's second round of trauma focus 6 weeks later.

Outcome and Prognosis

Mark attended every session except one, and completed almost all of his homework assignments. After years of avoidance (shutting out thoughts about the trauma), he did find listening to the taped narrative of his trauma very stressful (experiencing anxiety levels of 9 or 10 during each exercise), and reported a significant increase in sleep difficulties and nightmares intermittently during the 8 weeks he did his focused trauma work. As the trauma focus component of the treatment was drawing to a close, he spontaneously played the tape for his girlfriend so that "she could understand what (he) might have done wrong and why (he) was so screwed up." She was very supportive about the experience and this greatly relieved his tension. At that point, Mark decided to go back to his boss, inform him that he had been working on some personal issues, and ask for his job back. The supervisor agreed to rehire him on a probationary status. At the conclusion of the treatment, Mark opted to transition to an anger management class at the Vet Center in order to "get more control of my wicked temper." Although he still met diagnostic criteria for PTSD, his symptom severity had declined approximately 25%. He reported that he had found the TFGT content "somewhat helpful," but was especially appreciative of the feedback from his peers and for the opportunity to bond with other veterans.

CLINICAL ISSUES AND SUMMARY

At present there are no data from controlled treatment outcome trials for TFGT to provide the empirical support for its efficacy, although studies are currently underway. Pilot data from our early developmental work on the intervention procedure do suggest, however, that proportionally more individuals have been able to participate successfully in the intensive trauma exposure therapy in the group format than would have been anticipated within the context of individual sessions. In addition, drop-out rates in pilot groups have been lower than anticipated (usually in the 0–25% range). In virtually every case, dropping out has occurred early in the sequence before exposure work, suggesting that factors other than avoiding trauma reexposure may account for early termination.

Whereas the development of manualized TFGT has concentrated on chronic combat-related PTSD in Vietnam veterans, there are current efforts underway to adapt the approach for traumatized homeless women and war-exposed Bosnian adolescents. Glynn et al. (1997) have shown that manualized individual therapy (including exposure and cognitive restructuring) can be successfully combined with behavioral family therapy. Accordingly, another possibility for the future might be to combine TFGT with family therapy for those individuals where family issues are salient.

There are several active treatment components in the current form of TFGT, including education about PTSD, coping/relapse prevention skills training, personal autobiography, prolonged exposure therapy, cognitive restructuring, and group cohesion. The extent to which these treatment components are essential, individually or in combination, for positive TFGT outcomes is unknown. If initial controlled trials of TFGT produce promising results, research would need to focus on identifying essential treatment elements.

In terms of the clinical needs of thousands of veterans suffering from chronic combat-related PTSD, it appears that TFGT may be offered as a potentially beneficial alternative for those individuals who have been unable to benefit from traditional, individual forms of trauma therapy or support groups. However, criteria upon which to match individual clients to either group or individual forms of trauma processing therapy do not presently exist. Accordingly, it remains for future research to identify essential client and treatment characteristics by which efficient matching could be done.

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